Amendment No. 1 to SB1884

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AMEND Senate Bill No. 1884

House Bill No. 1881*

in Section 3 by deleting item (17) in its entirety and replacing it with the following:

- (17) "Resident" means:
- (A) An individual who has been legally domiciled in Tennessee for a minimum of thirty (30) days for persons eligible for enrolment in the pool under section (11)(b) of this act; or
- (B) An individual who is legally domiciled in Tennessee on the date of application to the pool and who is eligible for enrollment in the pool as a result of the federal health insurance portability and accountability act of 1996 for enrollment in the pool under section 11(a) of this act; or
- (C) An individual who is legally domiciled in Tennessee on the date of application to the pool and is eligible for the credit for health insurance costs under section 35 of the federal Internal Revenue Code of 1986 for enrollment in the pool under section 11(a) of this act.

AND FURTHER AMEND in Section 5 by deleting subsection (c) in its entirety and substituting the following:

Section 5.

- (c) The board shall be composed of:
- (1) Three (3) persons affiliated with an insurer admitted and authorized to write health insurance in this state, two (2) of whom must represent domestic insurers.
 - (2) One (1) person licensed to sell health insurance in the state.
- (3) Two (2) representatives of the general public who are not employed by or affiliated with an insurance company or plan, group hospital, or other health care provider, and can reasonably be expected to

qualify for coverage in the pool. Representatives of the general public include persons whose only affiliation with an insurance company or plan, group hospital service corporation, or health maintenance organization are as an insured or person who has coverage through a plan provided by the corporation or organization.

(4) One (1) person representing the medical provider community, such as a physician licensed to practice medicine in this state, a hospital administrator, or an advanced nurse practitioner.

AND FURTHER AMEND in Section 10 by deleting subsection (d) in its entirety and substituting the following:

(d) The pool shall determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques, and shall reflect anticipated experience and expenses for such coverage. Initial pool rate may not be less than one hundred twenty-five percent (125%) and may not exceed one hundred fifty percent (150%) of rates established as applicable for individual standard rates. Subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described in this subsection. In no event shall pool rates exceed one hundred fifty percent (150%) of rates applicable to individual standard risks.

AND FURTHER AMEND in Section 11 by deleting subsection (b) in its entirety and substituting the following:

(b) Any individual who is and continues to be a resident, as defined by Section 3(17)(A) of this act, and who is a citizen of the United States or has been a permanent resident of the United States for at least three (3) continuous years is eligible for coverage from the pool if the individual provides to the pool:

- (1) Notices of rejection or refusal to issue substantially similar insurance for health reasons by two (2) insurers. A rejection or refusal by an insurer offering only stop-loss, excess loss or reinsurance coverage with respect to the applicant shall not be sufficient evidence under this subsection;
- (2) A certification from an agent or salaried representative of an insurer, on a form developed by the board and approved by the commissioner, that states that the agent or salaried representative is unable to obtain substantially similar individual insurance for the individual with any state-licensed insurer that the agent or salaried representative represents because the individual will be denied coverage as a result of a medical condition of the individual under the underwriting guidelines of the insurer;
 - (3) Two offers to issue insurance only with conditional riders;
- (4) A refusal by an insurer to issue insurance except at a rate exceeding the pool rate; or
- (5) Diagnosis of the individual with one of the medical or health conditions listed by the board under Section 7(c) of this act. A person diagnosed with one or more of these conditions shall be eligible for pool coverage without applying for other health insurance coverage.

AND FURTHER AMEND in Section 11(a) by adding the following as item (3):

(3) An individual who is legally domiciled in Tennessee and is eligible for the credit for health insurance costs under section 35 of the federal Internal Revenue Code of 1986.

AND FURTHER AMEND in Section 11(e) by deleting item (5) in its entirety and by substituting instead the following language:

(5) Has premiums that are paid for or reimbursed under any governmentsponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider; of if the individual receives premium payment assistance through the federal health insurance tax credit established by section35 of the federal Internal Revenue Code of 1986.

AND FURTHER AMEND in Section 12 by adding the following language as a new subsection (b), and by redesignating subsequent subsections accordingly:

(b) The pool shall offer at least two different health benefit plan options to enrollees. Two different choices of annual deductibles shall be considered two distinct health benefit plan options.

AND FURTHER AMEND in Section 13, by adding the following language as new subsections to be designated as follows:

- (d) An eligible individual who is eligible for enrollment in the pool as a result of the federal Health Insurance Portability and Accountability Act of 1996, who has eighteen (18) months of prior creditable coverage, the most recent of which is employer-sponsored coverage, and who has exhausted all available COBRA or state continuation benefits will be eligible for coverage without regard to the 12-month pre-existing conditions limitation.
- (e) An eligible individual who is eligible for the credit for health insurance under section 35 of the federal Internal Revenue Code of 1986 will be eligible for coverage without regard to the 12-month pre-existing conditions limitation only if he or she has had three (3) months of prior creditable coverage as of the date on which the individual seeks to enroll in pool coverage, not counting any period prior to a 63-day break in coverage.

AND FURTHER AMEND by deleting Section 14 in its entirety, and by substituting instead the following language:

SECTION 14.

(a) For the purposes of providing the funds necessary to carry out the powers and duties of the pool, the board of directors shall assess member insurers at such time and for such amounts as the board finds necessary. Assessments shall be due in not

less than thirty (30) days after prior written notice to the member insurers and shall accrue interest at twelve percent (12%) per annum on and after the due date.

- (b) Each insurer shall be assessed in an amount not to exceed three dollars(\$3.00) per covered person or reinsured by each insurer per month.
- (c) The board shall make reasonable efforts designed to ensure that each covered person is counted only once with respect to any assessment. For that purpose, the board shall require each insurer that obtains excess or stoploss insurance to include in its count of covered persons all individuals whose coverage is insured (including by way of excess or stoploss coverage) in whole or in part. The board shall allow a reinsurer to exclude from its number of covered persons those who have been counted by the primary insurer or by the primary re-insurer or primary excess or stoploss insurer for the purposes of determining its assessment under this section.
- (d) The board, based on annual statements and other reports deemed to be necessary by the board, may verify each insurer's assessment. The board may use any reasonable method of estimating the number of covered persons of an insurer if the specific number is unknown.
- (e) If assessments and other receipts by the pool, board or administering insurer exceed the actual losses and administrative expenses of the plan, the excess shall be held at interest and used by the board to offset future losses or to reduce plan premiums. Future losses include reserves for claims incurred but not reported.
- (f) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment. As an alternative, the commissioner may levy a forfeiture on any member insurer that fails to pay an assessment when due. Such forfeiture may not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars (\$100.00) per month.